

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013226

STATE FILE NUMBER

1913

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5106 OLIVE ST.</u>		d. STREET ADDRESS (If outside, give location) <u>5106 OLIVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SEABURN WALLACE COFFMAN</u>		4. DATE OF DEATH Month Day Year <u>APRIL-15-1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 14-1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STUFFY FLORAL SUPPLY CO.</u>	11. BIRTHPLACE (City and state or country) <u>ARDMORE OKLA.</u>
13a. FATHER'S NAME <u>JOSEPH W. COFFMAN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY THOMAS</u>	14. NAME OF HUSBAND OR WIFE <u>SOPHRONIAN N. COFFMAN</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>441-01-8829</u>	17. INFORMANT Address <u>5106 OLIVE</u> <u>SOPHRONIAN N. COFFMAN - KANSAS CITY, MO</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLUS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CARCINOMA OF THE PANCREAS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>157X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u> <u>2 YRS</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>MAY 67</u> to <u>APR. 69</u> and last saw him alive on <u>15 APR. 69</u> Death occurred at <u>7:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wade E. Elliott M.D.</u> (Degree or title)		22b. ADDRESS <u>710 W 12<sup>TH</sup> S</u>	22c. DATE SIGNED <u>15 APR. 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/18/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS - KANSAS CITY, MO</u>		25. DATE RECD. BY LOCAL REG. <u>4-17-59</u>	26. REGISTRAR'S SIGNATURE <u>Wade E. Elliott</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Wade E. Elliott

MEDICAL CERTIFICATION

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### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed ..... *Wern Lawler* .....

Licensed Embalmer No. .... *4915* .....

P. O. Address ..... *K. C. Mo.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.